

Visit www.MDOptions.com

PHYSICIAN PRACTICE OPTIONS™

IMPROVING PATIENT CARE THROUGH INCREASED PRACTICE EFFICIENCY

October–November 2008

INNOVATIONS

Inconvenient Truths About Health Reform 2

STRATEGY

Reform Exacerbates PCP Shortages 3

COMMENTARY

Sustainable Business Models Needed 6

CAPITAL IDEAS

Can Tax Planning Recover Losses? 9

PRACTICE MANAGEMENT

Annual Kaiser Survey Shows Growth Among Workers Using HSAs 11

TECHNOLOGY

Search Services Get More Specific 14

INNOVATIONS

Inconvenient Truths About Health Reform

By Richard L. Reece, MD, editor in chief

Two recent articles in the *New England Journal of Medicine* offer lessons for health care reformers about what we can learn from the past about reform. In the first article (NEJM. 359(17):1749-51), Victor Fuchs, PhD, a retired Stanford economist, says national health reform should be initiated on the basis of three “inconvenient truths:”

1. Over the past 30 years, U.S. health costs have grown 2.8% faster than the rest of the economy.
2. Advances in medicine are the reason for this 2.8% faster growth, and they came mostly as a result of private-sector innovation.
3. Universal coverage will require national reform and financial sacrifice from individuals. Much of the cost burden for the sick and those Americans who can't afford to pay for health care will fall on the wealthy, the healthy, and others who can afford to pay.

In the second article (NEJM. 359(17):1751-5), Karen Davis, PhD, president of the Commonwealth Fund in New York, says that the United States should learn from other countries to develop innovative national strategies to cut spending. Based on predictive modeling by the Lewin Group, Davis presents a number of strategies that can be implemented to reduce health care spending. The savings for each strategy are projected over ten years. Projected savings are listed for the federal government, state and local governments, private payers, on a savings per household level, and in total. Each strategy is listed in terms of billions of dollars saved.

Davis' top 10 strategies for savings on a total national level are the establishment of a National Center for Medical Effectiveness and Health Care Effectiveness (\$368 billion in savings); the promotion of public health and prevention of obesity through new taxes invested in prevention programs (\$293 billion); the institution of Medicare episode-of-care payment (\$229 billion); strengthening primary care and care coordination in Medicare (\$194 billion); the promotion of public health by reducing tobacco use through new taxes invested in prevention programs (\$191 billion); limiting payment updates in high-cost areas (\$158 billion); limiting federal tax exemptions for premium contributions (\$131 billion); the application of Medicare provider-payment methods and rates to all payers (\$122 billion); the institution of competitive bidding between Medicare and private plans (\$104 billion); and the promotion of health information technology (\$88 billion).

“What is required is national leadership and commitment to moving toward a high-performance health system,” Davis asserts.

In other words, Big Brother will take care of you through federal innovations that include new taxes, programs, and regulations. It sounds to me a bit like “all for Medicare, and Medicare for all,” with national prevention programs to get Americans to change their smoking and eating habits, while payments to doctors are cut. I do not call this approach innovative.

—More information on physician practice strategies is available on our Web site (see page 16).

This newsletter is published by Premier Healthcare Resource, Inc., Morristown, NJ.

© Copyright strictly reserved. This newsletter may not be reproduced in whole or in part without the written permission of Premier Healthcare Resource, Inc. The advice and opinions in this publication are not necessarily those of the editor, advisory board, publishing staff, or the views of Premier Healthcare Resource, Inc., but instead are exclusively the opinions of the authors. Readers are urged to seek individual counsel and advice for their unique experiences.

Publisher

Premier Healthcare Resource, Inc.
150 Washington St.
Morristown, NJ 07960
973/682-9003; Fax: 973/682-9077
publisher@premierhealthcare.com

Editor

Joseph Burns
508/495-0246
editor@premierhealthcare.com

ADVISORY BOARD

Neil Baum, MD
Urologist
New Orleans

Daniel Beckham
President
The Beckham Co.
Physician and Hospital Consultants
Whitefish Bay, Wis.

Thomas M. Gorey, JD
President and CEO
Policy Planning Associates
Crystal Lake, Ill.

Michael B. Guthrie, MD, MBA
Executive Vice President
Premier, Inc. and
Premier Practice Management
San Diego

Harold B. Kaiser, MD
Allergy & Asthma Specialists, PA
Minneapolis

Nathan Kaufman
President
The Kaufman Group
Division of Superior Consultant Co. Inc.
Physician and Hospital Consultants
San Diego

Paul H. Keckley, PhD
Executive Director
Vanderbilt Center for
Evidence-based Medicine
Nashville

Peter R. Kongstvedt, MD, FACP
Senior Executive
Accenture
Health & Life Sciences Consulting
Reston, Va.

John W. McDaniel
President and CEO
Peak Performance Physicians, LLC
New Orleans

Lee Newcomer, MD, MHA
Senior Vice President, Oncology
UnitedHealthcare
Minneapolis

James G. Nuckolls, MD
Medical Director
Carilion Healthcare Corp.
Roanoke, Va.

Bernard Rineberg, MD
Physician Consultant
BAR Health Strategies
New Brunswick, N.J.

James M. Schibanoff, MD
Editor in chief
Milliman Care Guidelines
Milliman USA
San Diego

Jacque Sokolov, MD
Chairman
Sokolov, Sokolov, Burgess
Scottsdale, Ariz.

STRATEGY

Reform Exacerbates PCP Shortages

By Michael Bihari, MD

Few experts disagree that the U.S. health system needs to be reformed. Currently, more than 45 million Americans have no health insurance, and with a weakening economy and increasing numbers of Americans losing jobs, that number is likely to grow. Whether one believes in government mandates or free-market solutions, these experts argue that significant changes need to be made to the current health care reimbursement system.

Aside from the increased costs inherent in any reform plan, especially universal health coverage mandates, a significant issue is who will provide care for the potential wave of the newly insured. Any health reform in the United States that includes increased or mandatory coverage for the uninsured will underscore the question of physician-related supply and demand. There are likely to be many more patients and a lot fewer primary care physicians (PCPs).

A Case in Point

Some lessons can be learned from the recent health reform initiatives in Massachusetts, which significantly increased demand. The state is now trying to address the PCP supply issue.

On April 12, 2006, health care reform, including mandated universal health coverage, became law in Massachusetts. At the time, according to some estimates, more than 625,000 state residents had no health insurance. By September 2008, more than 435,000 residents had become newly insured, making Massachusetts the state with the lowest rate of unin-

insured in the United States.

A number of provisions in the health reform law in Massachusetts affect consumers and employers. The legislation:

- Requires nearly all adults in the state to carry health insurance
- Requires businesses with 11 or more full-time-equivalent employees to make a "fair and reasonable" contribution to employee health benefits, and to offer tax-free, payroll savings on health plan premiums
- Makes more residents eligible for MassHealth, the state's Medicaid program
- Promises better Medicaid rates to health care providers, and
- Creates a Cost and Quality

Council to address key health care concerns such as cost and reimbursement issues.

PCP Supply Shortage

The law established an independent state agency known as the Commonwealth Connector (at www.mahealthconnector.org) to ensure that the legislative mandates are implemented properly and to provide residents with easy access to information and services. The Connector is responsible for defining and setting standards for the health insurance that adults must carry, including what is considered affordable and the scope of coverage, including options for drug coverage
(Continued on page 4)

Massachusetts Requires Insurance Coverage

The 2006 legislation that launched health reform in Massachusetts created an independent state agency, the Healthcare Connector, to oversee the implementation of the reform programs.

To ensure that all residents comply with the universal health coverage mandate, the Connector established the following requirements and guidelines:

- Residents 18 and older must carry health insurance that meets the Connector's minimum coverage standards.
- Residents who pay state taxes and who are considered able to afford a health plan must enroll in one or incur tax penalties. In 2008, the tax penalties add up for each month that the tax filer does not enroll in a health plan. The total penalty could be as high as \$912 for an adult who does not carry health insurance for all 12 months in 2008.
- An adult who cannot afford a plan that meets the Connector coverage standards or who has a hardship can apply to the Connector for a penalty exemption. A waiver may be granted due to financial hardships and for those who do not get health insurance because of sincerely held religious beliefs.

—MB

As the disparity between primary care and specialty income has grown, fewer medical students are opting for primary care training programs.

STRATEGY

(Continued from page 3)

and preventive care.

To ensure access to health plan options, the Connector works with health insurers to create sufficient new health insurance options for individuals and employers. All major health insurers in the state have created portfolios of health plan options with varying benefit and premium alternatives. The Connector also works with adults and families who cannot afford any of the new health plans that meet the Connector's standards. Through a program known as Commonwealth Care, the Connector provides access to low- or no-cost health plans for qualified residents.

Within several months of implementing health reform mandates in Massachusetts, the shortage of PCPs became worrisome. This fact was echoed in newspapers, including, "Insured, Low-Income Massachusetts Residents Lack Access to Primary Care Physicians," "Lack of Primary Care Physicians May Derail Health Care Reform Initiative," and "New Health Law, Lack of Docs Collide."

The concerns of the newly insured and other health care consumers about access to primary care were verified in a report, *Physician Workforce Study*, published last month by the Massachusetts Medical Society (at www.massmed.org/workforce).

Facing a Crisis

In Massachusetts, a state with a highly educated and relatively affluent population, and famous for its university-based medical centers and world-renowned hospitals, more than 1.2 million residents (about 20% of the state's population) are medically disenfranchised.

Before health reform, access to primary care services was deteriorating in areas that were attracting large numbers of retirees, most notably on Cape Cod and in the Berkshire Mountains in the western part of the state, two well known tourist destinations. Because of a seasonal economy in these areas, many residents had no

State Aims to Address Shortages of PCPs

Within several months of the implementation of health reform mandates in Massachusetts, the shortage of primary care providers (PCPs) became worrisome. A report by the Massachusetts Medical Society, *Physician Workforce Study*, notes the erosion in access to primary care services and classifies the shortage of family physicians and internists as "critical." The report is available online (at www.massmed.org/workforce) and shows that:

- 35% of family medicine physicians are no longer accepting new patients, up from 25% in 2006.
- 48% of internal medicine physicians are no longer accepting new patients, up from 31% in 2006.
- Among physicians who are accepting new patients, the average wait time for an appointment with a family physician is 36 days; for an appointment with an internal medicine physician, the wait is 50 days.

Of great concern is the level of dissatisfaction among PCPs in Massachusetts. The study shows that 33% of family physicians and 29% of internal medicine physicians are considering changing their profession due to the current practice environment.

"Patient demands on these specialties have outstripped supply," the report says. "Furthermore, with the continued implementation of Chapter 58, a landmark health care reform law establishing mandatory health insurance enrollment for all Massachusetts residents, it seems very clear that these labor markets will face even greater stress."

To address issues related to the cost of implementing health reform and to help ensure access to primary care, Massachusetts lawmakers passed follow-up legislation earlier this year. The follow-up legislation:

- Creates a loan forgiveness program for doctors and nurses who commit to practicing in medically underserved areas
- Expands enrollment at the University of Massachusetts Medical School for students committed to primary care
- Creates an affordable housing model for health care professionals committed to providing care in underserved regions
- Requires health insurers to recognize and reimburse nurse practitioners as PCPs
- Directs the state to study methods of improving reimbursement or bonuses for professionals engaged in primary care.

Although these measures are a worthwhile attempt to ease the problem, they will take time to implement and several years to have any significant effect on physician supply. Meanwhile, patient demand continues to rise.

—MB

health insurance and received episodic care from local hospital emergency rooms and several free clinics. With the advent of health reform, the already strapped PCPs have not been able to keep up with

demand and many physicians have left the area in frustration, exacerbating the physician shortage.

An example of this issue is the town of Falmouth on Cape Cod. More than 25% of the town's resi-

dents are over 65 and the largest population growth is in people aged 55 to 64. In the year preceding and the year following implementation of health reform (during which more than 5,000 people in the Falmouth area became insured), more than a dozen PCPs stopped practicing.

Currently, most primary care practices in Falmouth are not accepting new patients or have stopped caring for Medicare patients. Open practices have an appointment wait time far exceeding the state average. A wait of 12 or more weeks for an appointment is common. Access is more difficult for those with Medicaid and the new state-subsidized health plans because most private practices do not accept them.

The major primary care safety valve in the community is the Community Health Center of Cape Cod, which cares for more than 5,000 patients. Because of demand, the health center has expanded rapidly, but with a growth rate of more than 200 new patients each month, it too is struggling to keep up.

Assessing Income Factors

Although the PCP shortage is partially due to an aging PCP population (meaning more physicians are leaving practice than entering) and an increasing percentage of women in the field who tend to work part time and often cut back on their hours to raise children, the major cause is clearly economic.

Thomas Bodenheimer, MD, summed up this issue best in a health policy report in the *New England Journal of Medicine*, "Coordinating Care—A Perilous Journey through the Health Care System" (NEJM. 358(10):1064-71.). Bodenheimer wrote, "With large panels of patients and a growing number of tasks to perform, PCPs can no longer provide

Report Says Millions Disenfranchised

Some 56 million Americans (nearly one in five) are 'medically disenfranchised' because they live in areas with insufficient numbers of primary care physicians to provide important primary and preventive care, said a report published last year. Published by the Robert Graham Center, a health policy research center that is part of the American Academy for Family Physicians and the National Association of Community Health Centers (NACHC), the report, *Access Denied: A Look at America's Medically Disenfranchised*, also said that in eight states, more than 40% of the population is medically disenfranchised.

The report is available from the NACHC (at www.nachc.com) and notes that the number of communities with too few primary care physicians is increasing as demand is projected to grow because of the large number of baby boomers who will turn 65 over the next several years. The addition of millions of newly insured Americans secondary to health reform will exacerbate an already critical situation.

—MB

high-quality short-term, long-term, and preventive care during a 15-minute visit, let alone perform care-coordination functions for which they are not reimbursed." It would take a PCP more than 7 hours per working day to provide all recommended preventive services to a typical patient panel, and an additional 10 or more hours per day to provide high-quality chronic disease management, he added.

With the lack of payment for cognitive services and reimbursement stagnant or falling compared with the rising cost of managing a practice, it should be clear to policy makers why physicians are leaving primary care or choosing specialty careers when they can.

As the disparity between primary care and specialty income has grown, fewer medical students are opting for primary care training programs. With an average debt of \$140,000, it is not surprising that the number of U.S. medical school graduates entering family practice residencies has

dropped by 50% since 1997, according to a recent article, "Future salary and US fill rate revisited" (JAMA. 2008; 300(10):1131-2). To provide comprehensive primary care services for the medically disenfranchised, whose ranks will swell with health care reform and an aging population, it is estimated that by 2015, the United States may need up to 46,000 additional PCPs.

Karen Gardner, executive director of the Community Health Center of Cape Cod, sees the problem, particularly in the growing numbers of unemployed seasonal workers opting for a state-subsidized health plan and the increasing percentage of Medicare beneficiaries. She has a fundamental question for health policy planners: Who will be here to treat them?

—Michael Bihari, MD, is a writer and editor in Falmouth, Mass., and the president of the Board of Directors of the Community Health Center of Cape Cod. More information on physician practice strategies is available on our Web site (see page 16).

Aging physicians leaving the field are not being replaced.

COMMENTARY

Sustainable Business Models Needed

By Richard L. Reece, MD, editor-in-chief

Just like in other industries, health care needs to develop sustainable business models that generate enough revenue to cover costs. Hope for transformations based on technological innovation such as personalized medicine using drugs developed to target individual genetic markers, minimally invasive procedures, Internet-guided algorithms for managing care, bonuses for superior performance, and enlightened and empowered consumers striving for more perfect health are insufficient to reform the system adequately.

The health care system will not be saved by lofty ideas such as the possibility of achieving great savings through information technology, illness-prevention programs, and coordinated care of patients with chronic diseases. These are all good ideas, and some may pay dividends in the long term, but they will not do so quickly enough and any reform measures need to be implemented soon.

Seeking Sustainability

“Much of what is discussed in virtually all forums as health care reform is really health care financing reform,” explains Scott Serota, president and CEO of the Blue Cross Blue Shield Association, which insures 102 million Americans and has networks that include 90% of doctors and 80% of hospitals. Serota was quoted in an article in *The New York Times*, “A Plan to Improve Health Care and Limit Costs,” in which he stated, “We really have not gotten sufficient

national attention on the real underlying issue, which is that the entire health care delivery system needs to be modified.”

American businesses already find it difficult to compete in the global marketplace because U.S. health care costs outstrip those of other developed nations. Similarly, U.S. hospitals are now competing with foreign hospitals, which have begun to attract American medical tourists who want elective surgeries in places that offer high quality and low cost. Thanks to the wide availability of information, U.S. employers and patients are finding they can get equivalent care abroad at a much lower price than they can get for similar services here in the United States.

Consequently, the American health care industry is learning to live within its means. Health care providers need to develop sustainable business models that rely on realistic revenue streams. To cut costs, major corporations and small and medium-sized businesses offering health benefits must turn away from specialty-dominated networks and look to patient-centered medical homes and to retail and worksite clinics. They must establish wellness programs and illness-prevention efforts that will help them improve workers' health, increase productivity, ward off chronic conditions, enhance employee satisfaction, and serve as recruiting tools.

The Blue Cross Blue Shield

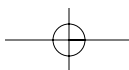
(BCBS) Association has proposed four starting points for a more financially sustainable system. First among these is the elimination of waste within the system, which totals approximately 30%, BCBS says. Second, the system must seek to reduce the incidence of pre-diabetes, which currently affects 57 million Americans, and is costly and leads to more costly conditions. Third, health organizations should cease to pay for avoidable hospital complications. And, fourth, they should reduce costs so that everyone, in both the private and public sectors, can afford to pay for health care services.

Looking Ahead

In 2004, President Bush announced the goal of creating and perfecting a national information system within a decade. The plan called for electronic medical record (EMR) systems in every physician's office that would be connected to similar systems in hospitals. Together, these components would form the backbone of a new and more efficient information system to replace the disparate and disconnected systems in place today.

The original national medical director of the proposed system has since resigned, and only 10% to 15% of practicing doctors have adopted complete EMR systems. For many doctors, especially those working in small practices, the EMR systems the Bush plan envisioned are too costly to install and maintain. Many physi-

To cut costs, major corporations and small and medium-sized businesses offering health benefits must turn away from specialty-dominated networks and look to patient-centered medical homes and to retail and worksite clinics.



Purchasers Focus on Consumer Responsibility

There is little argument that expanding health insurance coverage causes health care costs to rise. Unlimited entitlement programs encourage patients to seek care and providing such care is costly. Conversely, many health policy experts believe that encouraging patients to seek care from the most efficient and high quality providers may help to control costs.

To encourage patients to take care of themselves and engage in the practice of illness-prevention, several steps are required. One is that purchasers need to recognize that illness-prevention methods require physicians to spend more time with patients to counsel them about their conditions. Asking physicians to spend more time with patients means they would see fewer patients each day. Therefore, health plans may need to pay physicians more to spend more time with patients.

In addition, corporations may be able to help employees understand their health risks more fully by providing them with health-risk appraisals and developing on-site wellness programs to address these risks. Corporations also should be encouraged to establish worksite clinics at which illness-prevention is stressed and employees at risk for chronic disease would receive screening. The old adage "an ounce of prevention is worth a pound of cure" should be taken seriously.

A. Mark Fendrick, MD, and his colleagues at the University of Michigan have formed an organization known as the Center for Value-Based Insurance Design that aims to show purchasers how to get the most value from the care they are purchasing. This group has shown, for example, that when employers and other health care payers decrease co-payments for medications that offer clinical benefit to patients with chronic diseases such as diabetes, they can remove at least one cost barrier and help to improve patient outcomes as well.

Fendrick has data that show that in the process payers could save thousands of dollars by preventing complications simply by reducing co-pays and thus making medications more affordable for patients.

Another step aimed at preventing illness and empowering consumers came in December 2003. When Congress was considering the Medicare Prescription Drug Improvement and Modernization Act of 2003, it expanded the use of health savings accounts (HSAs). These accounts are usually linked to consumer-driven high-deductible health plans (CDHDPs). Shortly after HSAs were expanded, health maintenance organizations (HMOs), preferred provider organizations (PPOs), and other health plans began to increase the deductibles on all of their plans, thus shifting health care costs to employees and individuals.

By 2015, it is projected that nearly 25% of workers will be enrolled in HSAs, which health plans offer at a reduced premium compared with the premiums of HMOs and PPOs and allow those individuals and families that have these accounts to set aside funds for health care needs. Businesses are pushing HSAs in an attempt to control benefit costs. But critics of HSAs argue that these plans encourage patients to delay or avoid care.

When Congress was debating the issues involved with expanding HSAs, a number of health policy experts espoused the idea that government, and not individuals, should make health care choices for consumers.

But not everyone agrees, of course. A growing subset of consumers, including many well educated non-medical professionals, believe that by using the Internet to judge the value of health services they have the intelligence and access to sufficient data to choose their own care wisely and efficiently.

—RLR

cians believe EMRs are expensive, offer a negligible return on investment, decrease productivity, and disrupt normal practice patterns.

In addition, many physicians view EMR systems as punitive vehicles that health plans use to evaluate practices and exclude them from health care networks. Large enterprises such as Kaiser Permanente, the U.S. Veterans Administration, and the U.S. Department of Defense have shown it is possible to develop effective and efficient EMR systems, but adoption

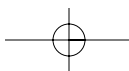
has remained stagnant among independent physicians.

To improve efficiency, the Medicare Payment Advisory Commission has urged Congress to pursue three initiatives: a medical home demonstration program, bundling of hospital and medical staff payments for all care during a given hospital admission to be paid to a single entity, and the creation of accountable care organizations much like existing large group practices. The underlying idea of such initiatives is to limit expenses by setting

budgetary caps and limiting fee-for-service options. Using these techniques, Medicare and Medicaid expenses may gradually be brought under control.

For health care in the United States to be truly reformed, Congress and health plans must be persuaded, through public sentiment and political processes, to abandon Medicare Advantage plans. These were created to market Medicare and serve as profit-generating programs for health maintenance organizations (HMOs). Health organizations must be per-

(Continued on page 8)



COMMENTARY

Health 2.0 Rises and Falters

In 2006, Matthew Holt and Indu Subaiya, health analysts and consultants in San Francisco, began the Health 2.0 movement. The main Health 2.0 Web site (<http://health20.org>) defines the term “Health 2.0” as “The use of social software and lightweight tools to promote collaboration between patients, their caregivers, medical professionals, and other stakeholders in health.” This definition derives from the document *The Wisdom of Patients: Health Care Meets Online Media*, prepared by Jane Sarasohn-Kahn, MA, MHSA, for the California Healthcare Foundation (at www.chcf.org).

An alternate definition of the term is “a new concept of health care wherein all the constituents (patients, physicians, providers, and payers) focus on value (outcomes and price) and use computers to compete over the full cycle of care as the catalyst for improving the safety, efficiency, and quality of health care.”

More than 500 professionals attended a September 2007 Health 2.0 conference including representatives of some of the largest technology companies, such as Google, Microsoft, Yahoo, and WebMD. The conference also attracted software entrepreneurs and others who create Internet sites for consumers and social networking. The second Health 2.0 conference, was held in San Francisco in October, and was sold out.

Interest in Health 2.0 is high partly because Google and Microsoft have entered the field of creating personal health records for individuals and employers. This new means of record-keeping is viewed as the missing piece of a national information technology system.

Three years ago, Steve Case, the founder of AOL, started the consumer-oriented Revolution Health site in an attempt to provide consumers with unlimited health care information to help them improve their health and

the efficiency of the health system simultaneously.

In October, Revolution Health merged with Waterfront Media, a company in New York that owns several health Web sites. The deal was valued at \$300 million and would give the two companies enough traffic in the United States to compete with WebMD, now the market leader in online health, according to *The New York Times*. The new company will operate under the name Waterfront Media, and the Revolution Health Web sites will be absorbed into Waterfront’s sites run by Everyday Health (at www.everydayhealth.com).

Health blogger Dmitriy Kruglyak sees the demise of Revolution Health as undermining the Health 2.0 movement. “In fact, they tried almost every Internet health idea under the sun,” Kruglyak says of Revolution Health in his blog on Sept. 14 (at <http://trusted.md/blog/hippocrates>). “Many of those came by way of acquisitions, while many were developed internally by copying competitors.”

Many Health 2.0 companies suffer from the illusion that offering wide access to information on the Internet will produce a sustainable business model. “The sooner people ditch the hype and focus on proving their claims with metrics, the faster we will realize the true promise of eHealth,” Kruglyak concludes. Part of the irrational exuberance of Health 2.0 may derive from the belief that, given enough information, health care consumers and purchasers will choose providers that offer lower costs and better quality of care. Yet, the leaders of Health 2.0 may have forgotten that too much information can overwhelm good judgment, and that consumers may trust their doctors rather than payer-generated information on the Web.

—RLR

(Continued from page 7)

sueded to accept all individuals who apply for membership, regardless of pre-existing illness or health risks; cease canceling claims from existing members who have become burdensomely expensive for HMOs to carry; compete with or join health plans fashioned after plans offered to members of Congress, government employees, and military veterans; and make premiums uniform across state lines. These will not be trivial adjustments.

If these adjustments are implemented, however, health plans will

have to do the following to survive:

- Stop paying hospitals for “never” events (such as complications in hospitals that should never occur, including infections, mismatched transfusions, venous thromboses, and surgical errors);
- Strive to cut the prevalence of obesity and type 2 diabetes;
- Reduce the 30% to 50% “waste” in the system, such as unnecessary, duplicative, and overly expensive imaging procedures; and
- Use information systems to identify, rate, and exclude physicians

who abuse the health system.

Both the American people and health providers must recognize that they can’t have it all and can’t afford total dependency on the government, with the ensuing tax burden. Health care organizations must begin to live within their means, while the American people learn to take better care of themselves, to pay more out of pocket for care, to exercise more, and to watch their weight.

—Edited by Rev DiCerto. More information on physician practice strategies is available on our Web site (see page 16).

CAPITAL IDEAS

Can Tax Planning Recover Losses?

Carole C. Foos, CPA, and David B. Mandell, JD, MBA

Recent developments have left many investors with less wealth than they had a year ago. For many physicians, it is likely that their homes and stock market investments are worth a lot less now than they were, and it may be years until those values return to previous levels. The federal government has recently agreed to spend hundreds of billions of dollars to bail out poorly run or mismanaged corporations. These bailouts will ultimately result in significant tax increases for all of us.

What many physicians and other providers may not know is that it may be possible to get the government to bail you out with some tax savings. The purpose of this article is to outline two simple steps to help investors regain some lost value. First, physicians must reduce their current taxes so they have more to add to a short-term investment portfolio. Second, physicians must focus on building wealth that is more tax-efficient for the long term.

Tax Reduction

If one can pay less in taxes in 2008 and 2009, it might be possible to recover a significant amount of any wealth lost recently. To reduce the amount of taxes one pays, there are three main techniques to consider.

1. Ensure that the physician group is using the right type of legal entity for the business it runs. Many physicians use the wrong owner-

Carole C. Foos, CPA, is an expert in tax analysis and tax planning services for O'Dell Jarvis Mandell, LLC, in Cincinnati. David B. Mandell, JD, MBA, is an attorney, lecturer, and author of Wealth Secrets: The Keys to Fortune Building and Asset Protection (John Wiley & Sons, 2008). More information is available online at www.ojmgroup.com.

A diversified tax portfolio can limit the risk of loss when taxes increase and provides flexibility that can enable a physician to minimize the total taxes paid over a lifetime of investing.

ship form for ideal tax planning. Choosing the best entity among "S" or "C" corporations, or limited liability companies, could yield tax savings of \$10,000 to \$45,000 annually.

2. Consider using a nonqualified retirement plan. Nonqualified plans are relatively unknown to many doctors, despite the fact that most Fortune 1,000 companies make nonqualified plans available to their executives. These plans should be attractive to doctors, because employee participation is often limited and inexpensive. Nonqualified plans also generally allow larger annual contributions for the owners than traditional qualified plans allow. Some plans allow annual contributions as large as \$200,000 per participating owner or executive.
3. Consider using a closely held captive insurance company (CIC), which can be an effective tool for successful medical practices seeking liability protection, risk management, and tax and wealth accumulation benefits. CICs are small insurance companies that will insure physicians against losses from liability claims. These types of companies enjoy beneficial tax treatment, allowing business owners an opportunity to build wealth, as opposed to sending profits to insurers. These and other techniques could

help a physician reduce taxes for 2008 or 2009 and thus to recover a percentage of any wealth lost as soon as this year. For more sustainable wealth recovery, a physician may need longer-term tax strategies.

Long-Term Efficiency

Tax and investment counselors often advise physicians and other professionals to spread funds across different classes of investment so that, in the event something bad happens that affects one company or one industry, the event does not significantly harm the entire portfolio. A similar theory applies with tax diversification. If a doctor has some investments that may be taxed as ordinary income, some that may be taxed at capital gains or dividend tax rates, and some that may not be taxable at all, then a physician has some flexibility.

A properly tax-diversified portfolio minimizes the risk of loss when taxes increase and provides flexibility that can afford a savvy taxpayer the opportunity to minimize the total taxes paid over a lifetime of investing. For this reason, we advise physicians to have their wealth in multiple tax "buckets," each with its own tax treatment. Doing so provides flexibility that allows physicians to minimize the taxes paid over the long term and could also help to make up for any wealth lost recently.

Tax diversification is especially important for the long term because

(Continued on page 10)

CAPITAL IDEAS

(Continued from page 9)

tax rates today are extremely low. The top marginal federal income tax rate, which was at 73% in 1920 and 91% in 1960, is now at 35%, close to an historic low. Also, capital gains taxes, which were at 32.3% in 1970 and 39.9% in 1977, are currently at an historic low at 15%. Given these facts, physicians seeking to recover wealth from recent losses over the long term must assume that tax rates will go up, rather than down.

Too many physicians have their wealth in two buckets: qualified retirement plans, such as pensions, 401(k)s, or SEP IRAs; and personally held taxable assets, such as personal securities investments and real estate. The disadvantage to having wealth in these two buckets is that both of these asset classes are subject to future increases in income tax rates, capital gains tax rates, or both. Whether one plans to take funds out of a 401(k) or SEP IRA in retirement or one plans to sell stock or live off bonds, a physician will have no idea now what the tax rates will be on that income in the future. Given what is known about the historic range of possibilities for tax rates, it is clear that the rate in the future could easily be much higher than it is today.

Seeking Tax Immunity

Unfortunately, too few physicians have diversified enough into a non-taxable wealth bucket. By doing so properly, physicians can insulate much of their wealth from future tax increases, but also can begin to “make up” some of the recently lost wealth over the long term. Such tax-immune buckets include Roth IRAs, nonqualified retirement plans, and private placement life insurance. One such nonqualified plan is treated as a hybrid plan with qualified and

Comparing Different Investment Options

| | Qualified plan | Personally held taxable investments | “Hybrid” nonqualified plan |
|---------------|-----------------|---|----------------------------|
| Contributions | 100% deductible | No deduction | 40% deductible |
| Growth | Tax-deferred | Taxable (can be ordinary income or capital gains) | Tax-deferred |
| Withdrawals | Ordinary income | Capital gains | Tax-free |

nonqualified elements. It is a flexible plan that has numerous benefits for a practice. The contributions are partially deductible and partially taxable at the outset.

From a current tax perspective, such a plan is more attractive than personally held taxable investments, which offer no deduction and are less attractive than qualified plans that offer a 100% deduction. In a nonqualified plan, the funds grow tax-deferred, as they do under a qualified plan. This tax-deferred growth makes a nonqualified plan more desirable than the personally held taxable investments. The holder can access funds in a nonqualified plan without any tax liability. Such accessibility makes a nonqualified plan more desirable than personally held taxable investments or a qualified plan. Such a plan can avoid the risks of increases on future income and capital gains tax rates and acts as an ideal long-term recovery plan for lost wealth.

Hybrid Versatility

In addition to helping to hedge against future tax increases and providing some wealth recovery, a hybrid plan can be used in conjunction with a qualified plan such as a pension,

profit-sharing plan, 401(k), or SEP IRA. In most states, the funds in the plan can grow in an asset protection environment. Maximum contributions for such plans are \$100,000 per doctor in practices with 10 employees or fewer. In larger practices, these levels can be higher. In a group practice, not every doctor is required to contribute the same amount. Such flexibility is beneficial for group practices that have doctors who want to put away different amounts of money. In addition, there are no minimum age requirements for withdrawing income and no early withdrawal penalties. Finally, the transfer of assets after the doctor’s death is income tax-free to his or her heirs.

Given that investors have all lost some wealth in the past year, the key to future financial success is how one reacts after a loss. For those seeking to recover lost wealth quickly in the short term and on an ongoing basis in the long term, it may be prudent to focus on tax planning. By doing so, physicians can get a jump on all those investors who will complain about what has happened but fail to invest and plan intelligently.

—More information on physician practice strategies is available on our Web site (see page 16).

Given that tax rates are at historic lows, physicians must assume that over the long term rates are likely to rise, rather than go down.

PRACTICE MANAGEMENT

Annual Kaiser Survey Shows Growth Among Workers Using HSAs

Enrollment in consumer-directed plans continues to grow, rising to 8% of all workers from 5% last year, according to a recent survey by the Kaiser Foundation. This finding is one of the key results from the 2008 survey. Other key findings from the survey include increases in the average single and family premiums and an increase in the percentage of workers enrolled in high-deductible health plans with a savings option (HDHP/SO). Cost sharing for medical services has also increased in recent years. The percentage of employers sponsoring insurance and the percentage of workers covered by employer-sponsored insurance remained stable over the past year.

Physicians are likely most interested in enrollment in consumer-directed plans because patients in these plans typically pay cash for health care services. Enrollment in these plans is growing most rapidly in small businesses. This year, 13% of workers at small businesses were enrolled in such plans and last year, 8% of workers at small businesses were enrolled in these plans. In businesses with 200 or more employees, 5% of workers are enrolled in consumer-directed plans currently, a percentage that was unchanged from last year.

The survey of U.S. businesses

showed that businesses were interested in consumer-directed plans with high deductibles because the premiums were much lower than the premiums for more traditional plans, such as HMOs and PPOs. Consumer-directed plans include tax-preferred savings options such as a health savings account (HSA) or a health reimbursement arrangement (HRA). High-deductible plans with an HSA or HRA accounted for 5% of insured workers in 2007, an increase from 4% in 2006. This year consumer-directed plans account for 8% of insured workers the survey said.

The average annual deductible for an HSA-qualified plan is \$2,010 for single coverage. For an HRA-qualified plan, the average annual deductible is \$1,552 for single coverage.

Lower Premiums

Consumer-directed plans in general have lower premiums than other types of insurance plans, not including the funds employers contribute to employees' savings accounts. The average annual employer contribution to a savings account for an HSA-qualified plan is \$1,522 for family coverage. This amount is in addition to an average premium of \$8,291 annually for family coverage paid by an employer for such a plan.

For non-consumer-directed plans, employers contribute \$9,495 annually on average for family coverage.

The primary reason cited by six out of 10 businesses for offering consumer-directed plans is cost. More than four out of 10 businesses claim that the lower cost has been the most desirable aspect of these plans. The greatest challenge in adopting such plans cited by four in 10 employers is informing and educating employees about the plans.

Rising Costs

Results from the 2008 Employer Health Benefits Survey produced by the Kaiser Family Foundation and the Health Research & Educational Trust show that health insurance premiums rose only 5% this year, even though they have more than doubled since 1999. On average, the premium for employee-sponsored family coverage health insurance is \$12,680 this year. Of that total, employees pay \$3,354 on average out of their wages annually. The data were compiled from a telephone survey of 1,927 large and small, public and private employers.

While premiums have risen, the nature of coverage has changed. High-deductible plans have become significantly more prevalent in recent years, requiring workers to pay more out of pocket when care is given before insurance takes over. This year, 18% of insured workers had deductibles of \$1,000 or more, compared with 12% of insured workers last year. Workers in small companies are most likely to have high deductibles. In 2008, 35% of workers in small companies had insurance coverage with high deductibles, compared with 21% in 2007. Deductibles associated with PPOs have risen nearly \$100 on

(Continued on page 12)

Average Health Insurance Premiums

And workers' contribution for family coverage

| | 1999 | 2008 |
|------------------------------|---------|----------|
| Employee contribution | \$1,543 | \$3,354 |
| Employer cost | 4,247 | 9,325 |
| Total | \$5,791 | \$12,680 |

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2008.

PRACTICE MANAGEMENT

(Continued from page 11)

average since 2007, to a current average of \$560.

Employees' premium contributions and deductibles on average are likely to rise again in the next year. The likelihood of raising premium contributions was ranked as "very likely" by 14% of businesses polled, while the likelihood of raising deductibles was ranked as "very likely" by 12%, the survey showed.

Factors Affecting Care

The rising cost of health insurance can be seen as a contributing factor to many of the problems the health insurance industry faces today. High deductibles can cause workers to delay treatment or avoid visiting their doctors, researchers say. They also can contribute to delays in payment, which is a major concern to most physicians. High premiums are a contributing factor in some businesses' decision to decrease coverage or, in some cases, to stop providing insurance altogether.

The most popular type of insurance in 2008 is the PPO. This year, 58% of insured workers are enrolled in PPOs. The least popular type of insurance is conventional indemnity. These plans account for only 2% of workers. Consumer-directed plans account for 8% of insured workers, while point-of-service plans account for 12%. The second most popular type of plan with employers is the health maintenance organization (HMO). This year, 20% of insured employees are enrolled in HMOs.

Fewer Benefits

Some of the most revealing data in the study were those involving conditions at smaller businesses. Health benefits are more or less ubiquitous in large businesses. However, workers at small businesses are much less likely to be offered such benefits. Only 62% of businesses with fewer than 200 employees currently offer health benefits. That figure is even smaller for very small businesses, those employing

Employee Contributions Are Continuing to Rise

Among the results from the Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2008, physicians may want to note in particular that the majority of workers have to pay a portion of the cost of physician office visits. Seventy-nine percent of covered workers have a copayment for a physician office visit and 11% have coinsurance.

Workers and family members in HMOs, PPOs, and POS plans are more likely to face copayments, while workers and family members in high-deductible health plans with a savings option (HDHP/SOs) are more likely to have coinsurance requirements or no cost sharing after any deductibles are met.

Among insured workers with a copayment for in-network office visits, the average copayment is \$19 for primary care and \$26 for specialty physicians. For covered workers with coinsurance, the average coinsurance is 17%, the survey shows.

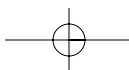
Most covered workers also must pay a portion of the cost for prescription drugs. Over three-quarters of insured workers are in plans with three or more levels or tiers of cost sharing that generally are based on the type or cost of the drug, the survey shows. Copayments are more common than coinsurance for the first three tiers. In the fourth tier, workers have copayments or coinsurance. Among workers with three- or four-tier plans, the average copayments are \$10 for first-tier drugs, often called generics, \$26 for second-tier drugs, often called preferred, and \$46 for third-tier drugs, often called nonpreferred. The average copayment for fourth-tier drugs is \$75 and the average coinsurance is 28%.

Most insured workers and family members must pay a share of the cost when admitted to a hospital or when they have outpatient surgery. In addition, they would have to pay any general plan deductible. Cost sharing may include a separate deductible, copayments, coinsurance, or a per diem charge for hospital admissions. Among insured workers, 37% have coinsurance for hospital admissions and the average coinsurance rate is 17%. For the 24% of workers with copayments, the average copayment is \$216 per hospital admission. About 3% of covered workers have a per day (per diem) fee for hospital admissions, and the average per diem charge is \$193. Another 3% of covered workers have a separate annual hospital deductible, and the average separate annual hospital deductible is \$401.

from three to nine workers. Only 49% of businesses of this size offer their employees health benefits. Some 48% of owners of small businesses cited the cost of insurance as the primary reason for not offering health benefits.

Workers at small businesses not only were less likely to be offered health benefits, but also when health benefits are available to employees of small businesses, these workers on average are required to pay higher premiums for family coverage than

employees of larger businesses, the survey showed. Insurance premiums cost employees of large businesses on average \$2,982 annually for family coverage; employees of small businesses on average pay \$4,101 annually for the same level of coverage. Single workers at small businesses fare somewhat better, however. Premiums for single coverage for employees of small businesses average \$624 annually; employees of large businesses pay an average of \$769 per year.



Focusing on Wellness

A surprising finding of the study was in the area of employer-sponsored wellness programs. Among the various types of wellness programs are on-site exercise equipment or discounts on gym memberships, programs to help employees quit smoking, wellness newsletters, weight-loss programs, nutrition classes, Web-based resources, and personal health coaching. More than half of businesses that offer employee health benefits provide these types of wellness programs.

Among large businesses offering wellness programs, 79% report that they believe these programs improve their employees' health, while 68% report that they believe these programs reduce overall health care costs.

Some companies offer incentives to workers who participate in wellness programs. These incentives include travel, cash, merchandise, gift cards, and lower deductibles or reduced premiums offered in an attempt to encourage employees to take advantage of employee-sponsored wellness programs. Relatively few employers offer these types of incentives, however. Only 7% of employers offer travel, cash, merchandise, or gift cards, while only 1% offer a reduced deductible and only 4% offer reduced premiums for employees participating in wellness programs.

To identify employees who would be appropriate to participate in wellness programs, employers use health-risk assessments. These assessments offer employees an opportunity to be screened to identify conditions for which they may be at risk. Of businesses offering employee health benefits, 10% offer health-risk assessments. Some 12% of businesses that offer these assessments provide a financial incentive to employees who complete these assessments.

Sharing the Burden

In addition to reporting data specifically on employee health benefits, the Kaiser/HRET Survey of Employer-

Survey at a Glance

The recently released 2008 Employer Health Benefits Survey produced by the Kaiser Family Foundation and the Health Research & Educational Trust contains a wealth of data on employer-sponsored health insurance. The data were compiled from a telephone survey of 1,927 public and private employers. Employers surveyed were selected randomly and included both small (three to 199 employees) and large (200 or more employees) businesses. The complete survey can be accessed at <http://ehbs.kff.org/>.

Areas of focus for the survey included changes in costs to businesses and employees for insurance benefits, the prevalence of preferred provider organizations (PPOs) as insurance providers, and the increase in enrollment of employees in health savings account (HSA)-qualified plans. The differences in benefits offered by large versus small business were also quantified, as were the availability to employees of retiree health benefits and wellness programs.

Sponsored Health Benefits, 2008, includes information on employee contributions to the cost of care. As the cost of health insurance rises, the percentage of covered workers in health plans with deductibles of at least \$1,000 for single coverage has grown from 10% to 18% over the last two years and, among small firms, the percentage of covered workers with a deductible of at least \$1,000 has increased from 16% to 35%, the survey shows.

This result means workers and family members are paying more for care, a factor physicians may want to note particularly for workers and family members who are in high-deductible health plans. If workers in these plans cannot pay their deductibles or coinsurance amounts, the physicians could be stuck with unpaid bills.

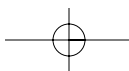
About 68% of workers in PPOs have a general annual deductible for single coverage that must be met before the plan will pay for all or most services, for example. Half of workers in point of service (POS) plans and 20% of workers in HMOs have a general annual deductible for single coverage. Many workers with no deductible have other forms of cost sharing for office visits or other services.

But employers also are making an effort to foster certain types of care

because some plans cover services before the deductible is met. The survey shows that 89% of covered workers with a general annual deductible enrolled in PPOs (which is the most common plan type) do not have to meet the deductible before preventive care is covered. Ninety-two percent of workers in PPOs do not have to meet the deductible before prescription drugs are covered.

The average general annual deductible for workers with a deductible for single coverage is \$560 for workers in PPOs, \$503 for workers in HMOs, \$752 for workers in POS plans, and \$1,812 for workers in high-deductible health plans with a savings option (HDHP/SOs). Of course, these workers have chosen high deductibles. From 2007 to 2008, the general annual deductible for workers in PPOs with a deductible increased from \$461 to \$560 for single coverage and from \$1,040 to \$1,344 for workers with an aggregate deductible for family coverage, the survey shows.

Workers in small companies (meaning those with 3 to 199 workers) have higher deductibles than workers in large businesses (200 or more workers) for PPOs, POS plans, and HDHP/SOs. —More information on physician practice strategies is available on our Web site (see page 16).



TECHNOLOGY

Search Services Get More Specific

By Richard L. Reece, MD, editor-in-chief

Have a moment to spare? That's good, because most busy clinicians have little time to waste. You have probably just reached the end of a long practice day, and have a few unanswered questions that linger from the 20 or so patients you have seen. You would also probably like a quick, easy way to find relevant and recent answers to your questions. You would no doubt like those answers to be authoritative and targeted to your specialty or to problems confronted recently.

You are most likely Internet-savvy and have probably already gone to the all-encompassing Google, or maybe PubMed, the massive U.S. government Web site, for your answers. You have most likely found that these sites too often yield long lists of articles or bits of information that take too long to scroll through and often are clinically irrelevant or outdated.

Not so long ago, there were few options available online for physicians seeking answers to questions about practice management. Today, however, the Internet presents a host of useful options for finding relevant and timely information on how to run a practice. A good example, though far from the only one, is the free Web site SearchMedica.com.

Other sites that physicians can use for practice management information include those for some of the nation's largest consulting firms and practice management consultants. These firms typically have sections on health care that offer a wealth of information on business topics appropriate for physi-

cians. One of the most comprehensive is the Web site of Peak Performance Physicians LLC, physician practice management advisers in New Orleans (at www.peakphys.com). This site is run by John W. McDaniel, the president and CEO of Peak Performance Physicians, and his staff.

Guaranteed Results

This site offers a list of topics including a section on practice improvement and a list of newsletters available from this year and years past that offer a wealth of information on various topics important to the efficient running of a physician group.

Over the past 20 years, Peak Performance Physicians has worked with hundreds of hospitals and medical practices seeking a physician practice management assessment and business plan. In this comprehensive analysis, McDaniel examines the five levers of profitability for practice improvement:

1. Reimbursement systems
2. Billing and collection processes
3. Accounts receivable management
4. Operations improvement and
5. Practice growth.

Articles about McDaniel's five levers of profitability were published last year in *Physician Practice Options* and are available online (at www.mdoptions.com).

Earlier this year, McDaniel reported that the results client physicians have received over the years have been so remarkable that Peak Performance Physicians now offers a guarantee to physicians. Upon implementing

McDaniel's recommendations as a result of his assessment and business plan strategies, the company guarantees to refund the physician group's fee in full if the group does not achieve bottom line improvement equal to or greater than the fee within 12 months. Granted, this service goes well beyond what a physician would expect to find by conducting an Internet search for practice management strategies, but it does show that many more resources are available to physicians who are willing to search for practice management assistance than were available just a dozen years ago, for example.

One site that includes years of examples of practice management resources is the site affiliated with this newsletter, MDOptions.com (at www.mdoptions.com). This site is the home for all newsletters that are part of the Practice Options family, including *Diabetes Practice Options*, *Ophthalmology Practice Options*, *Rheumatology Practice Options*, and others. Since the newsletter was founded in 1996, we have collected all our articles in a searchable database. Our newsletter was recently recommended by the Physicians' Foundation for Health Systems Excellence (at www.physiciansfoundations.org) in Irving, Texas.

Other popular sites for practice management information are those offered by large medical associations, such as the AMA (at www.ama-assn.org), the American Medical Group Association (at

If the current crop of online practice management tools has one shortfall, it might be a failure to specifically cover some of the burning broader issues of today in one category.

www.amga.org), and Medical Group Management Association (at www.mgma.com), and specialty associations such as the American Academy of Family Physicians (at www.aafp.org).

Finding More Options

Those organizations that are developing sites for physicians have built their success on the assumption that busy doctors are using the Internet and want clinically focused, timely answers to pressing questions.

Lois Wingerson, content editor of SearchMedica.com (www.searchmedica.com), says the site's developers based their site on this assumption when United Business Medica, based in London, and its subdivision, CMPMedica, Ltd., launched the Web site in 2006. After it started in the UK, SearchMedica.com became such a success that it expanded to the United States two years ago. Along with a host of other online practice management resources, SearchMedica.com has begun to fulfill a specific and long-neglected need. The company's operations in the United States are in Darien, Conn.

To make its information authoritative and clinically relevant, SearchMedica.com vets all of its information through experts in the United States and abroad. In addition to a version for use in the United Kingdom, SearchMedica has versions for physicians in France and Spain. Each day it has hundreds of thousands of page views.

Research and Markets (at www.researchandmarkets.com), which bills itself as the world's largest market research resource, explains in a report, *Physician Targeted Websites: Understanding the Online Needs of Physicians*, that physicians in Europe and the United States are using health Web sites and physician Web sites as their primary sources of health information online. "Physicians in the United States are more likely to spend a longer period of time on one specif-

Practice Management Information Abounds

A wide variety of online resources are available for physicians seeking practice management information. A general search on a topic of interest, such as "medical billing," will yield hundreds of results. Many of these, however, will not be geared toward physicians. Therefore, it may make more sense to tell your search engine you want practice management advice for physicians.

Simply typing "medical practice management" into Google yielded more than 11 million results, which is obviously way too many to be useful to busy clinicians. Fortunately, one of the top links was to the home page for the Medical Group Management Association (at www.mgma.com). This well respected organization's site features links for practice management, professional development, member community, career center, and specialty information. There is also a section on Practice Solutions, featuring links to topics such as billing, electronic health records, and physician compensation.

Other sites to consider are those of the AMA, the AMGA, and the MD Options Web site (www.mdoptions.com). —RLR

ic Web site than European physicians," said the report, which was published in 2004. "Physicians from both regions are primarily searching for health news and broad-ranging product and disease information."

The Research and Markets report provides information on physicians' online behavior and analyzes the critical success factors required for a health information Web site for physicians. In both Europe and the United States, the most commonly used online sources of health information are general health Web sites and physician Web sites.

Interestingly, the report also says that it surveyed physicians in the United States and Europe and found that three-quarters of those responding wanted more disease information on physician-targeted Web sites and that physicians from the United States and Europe are interested in seeing more product-specific information and treatment pattern information.

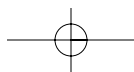
Filling Needs

If the current crop of online practice management tools has one shortfall, it might be a failure to specifically cover

some of the burning broader issues of today, such as Medicare mandates, shrinking reimbursements, physician shortages, decreasing access to care, and policy issues in general, in one category for current events. But perhaps expecting these issues to be organized into a single category is a bit too much to ask. These issues are not solely clinical and cross philosophical, ideological, and political boundaries, and are therefore hard to categorize.

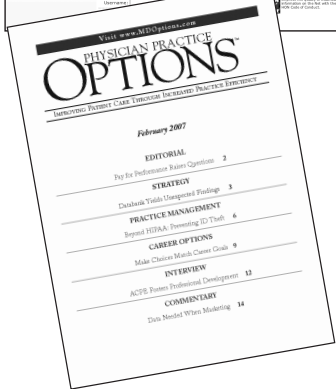
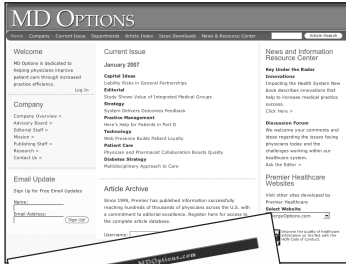
The founders of SearchMedica.com and the many other online practice management sites believe they have developed Web sites that allow clinicians to find exactly what they want to know quickly and without the endless scrolling through long lists generated by such generic Web sites as Google or PubMed. Many sites could be considered agnostic in that they do not favor one source over another and neutrally cover the clinical landscape. Physicians should be aware, however, that other sites have a point of view and may want to steer readers in a particular direction.

—Edited by Rev DiCerto. More information on *physician practice strategies* is available on our Web site (see page 16).



IMPROVING PATIENT CARE THROUGH INCREASED PRACTICE EFFICIENCY

**MD
OPTIONS.com**



Our FREE online resource includes:

- ▼ Strategies and tactics to build your practice
- ▼ A complete database searchable by keyword, subject, or issue
- ▼ Interaction with experts on all aspects of the Business of Medicine™
- ▼ Links to business resources, such as practice management, marketing, and CME
- ▼ E-mail updates on the latest developments in the Business of Medicine™

E-MAIL UPDATES


Let MDOptions.com come to you! MDOptions.com can keep you up to date automatically on the latest developments in the **Business of Medicine™**. You can sign up at MDOptions.com or fill in your name and e-mail address below and fax it to us at **973-682-9077**.

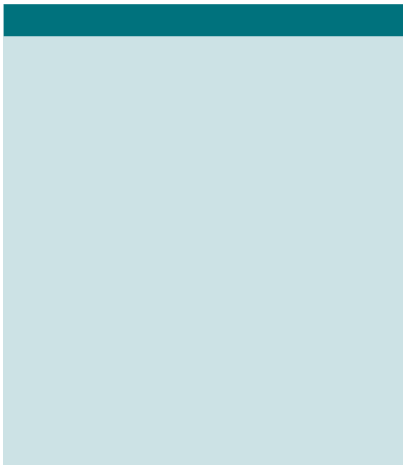
Name: _____

E-mail: _____

**PHYSICIAN PRACTICE
OPTIONS™**

IMPROVING PATIENT CARE THROUGH INCREASED PRACTICE EFFICIENCY October-November 2008

 Premier Healthcare Resource
150 Washington St.
Morristown, NJ 07960



10-11/08

